Exhibit 5

UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF MICHIGAN

SOUTHERN DIVISION

JACK REESE, FRANCES ELAINE PIDDE, JAMES CICHANOFSKY, ROGER MILLER, and GEORGE NOWLIN,

Plaintiffs,

vs. Case No. 2:04-cv-70592-PJD-PJK

Hon. Patrick J. Duggan, U.S.D.J.

Hon. Paul J. Komives, U.S. Mag. J.

CNH GLOBAL N.V. and CNH AMERICA LLC,

Defendants.

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The Deposition of SUZANNE MARIE DANIELS, Ph.D.

Taken at 400 Galleria Officentre, Suite 117

Southfield, Michigan

Commencing at 9:28 a.m.

Friday, January 10, 2014

Before Mary Jo Power, CSR-1404, RPR, RMR, CRR

A. That's not what I was asked to look at.
Q. So you don't have an opinion on that?
A. I don't.
Q. Okay. This -- we've been going for about -- how long? Let's go for a little bit longer. We can get a little bit more done, I think. I'm eager to get you out of here with appropriate dispatch.

And as with the other benefit plans, you weren't asked to form an opinion as to whether the Dana Corp plan was more generous, less generous, or about the same as the CNH proposal here, were you?
A. I was not asked to form an opinion.
Q. And you don't have an opinion?
A. I was not asked to form an opinion.
Q. I take it --
A. Beyond the scope of my work.
Q. And so I take it that means you don't have an opinion.
A. That is correct.
Q. Thank you.

Dr. Daniels, your work in the health care area has -- I assume that you have followed the issues of some of the major entities in the Detroit area with regard to their retiree health care liabilities; is that right?
A. Could you be more specific?

Q. Sure.
A. -- as to the entities?
Q. Sure.
You know that both business and governmental entities in the greater Detroit area have had -- have struggled with their retiree health care liabilities in recent years, right?
A. There are some entities that have struggled in recent years.
Q. In fact, the former treasurer of the state of Michigan opined in court just a couple of weeks ago that the principal reason Detroit went into bankruptcy was retiree health care benefits.
Didn't you -- did you read that?
A. I read that.
Q. And do you disagree with that assessment?
A. Detroit is far more complex than just retiree health care as it relates to the bankruptcy.
Q. But you would agree that the retiree health care obligations of Detroit are at least a material contributing factor to Detroit's decision to go into bankruptcy?
A. They are a factor. I have not personally reviewed the numbers to say whether or not they are material -- it's a material reason.

MR. BURCHFIELD: Let me ask the reporter to mark as Daniels Exhibit 12 an article from the Detroit Free Press dated November 5, 2013, entitled Dillon: Retiree Health Care, Not Pension Shortfall, a Core Reason for Detroit Bankruptcy.

MARKED BY THE REPORTER:

DEPOSITION EXHIBIT 12

10:48 a.m.

BY MR. BURCHFIELD:

Q. Dr. Daniels, do you have in front of you Daniels Exhibit 12?

A. I do.

Q. And do you see there in the first paragraph it says, Former Michigan Treasurer Andy Dillon said Tuesday that Detroit's retiree health care commitment was a core reason why the city filed for bankruptcy and that the city's pension shortfall wasn't the driving factor, unquote?

A. I see that language.

Q. And that -- and you saw the news reports of that testimony, I assume?

A. I did not see this one.

Q. Dr. Daniels, would you agree with me that every day CNH's ability to implement the changes that it's proposing in retiree health care benefits are delayed,

the retirees receive a financial benefit?
A. I don't think I can answer with a simple yes or no.
Q. And what about the question do you find difficult?
A. "Every day."
Q. Well, let's say every month. Would you agree that every month the changes that CNH is proposing are delayed that the class of retirees in this case receive a financial benefit?
MR. CANZANO: I --
THE WITNESS: No.
MR. CANZANO: I'm going to object because it assumes -- it assumes that there is a right to make that change.
MR. BURCHFIELD: I don't -- I don't -- if that's the way you understood the question, let me make sure that that assumption is not reflected in the question.
BY MR. BURCHFIELD:
Q. In the event CNH were to have a right to make the changes, every month that those changes are delayed the retirees receive a financial benefit, correct?
A. Retirees who access services will pay less than under the proposed plan.
Q. And that's a benefit to them?
A. Correct.

A. It was -- yeah, 4300, because they had paid the retainer.
Q. Okay. I'm looking at the $8,000 figure in your report, but they're current on the invoices you've tendered?
A. Yes, they are.
Q. All right. Now let me look at -- let's look at attachment 2, which is on page 22 of Daniels Exhibit 6, and can you just confirm for the record that this is the list of materials that you have relied upon in connection -- in preparing your report, plus any additional materials cited in the footnotes of your report?
A. Yes, I believe this encompasses everything.
Q. Okay. Did you -- could you describe what if any literature search you did in preparing your report?
A. I did an extensive literature review in order to address the focus that I was asked to look at, and that would be the impact of changes in plan on the retirees. So I researched the current literature that's published and peer reviewed to find information in that area.
Q. And about how many hours did you spend on that extensive review?
A. It's listed in here. Three, four, five, roughly.

Q. So March 31 and June 1 I see literature review entries totaling four hours. Is that it?
A. That's about right, yep.
Q. Okay. And you were satisfied that your literature review in that four hours was sufficient to render the opinions that you've rendered in this case?
A. Yes.
Q. Okay.
A. I have reviewed the literature in this area before.
Q. So obviously you relied upon your extensive experience as an economist in the health care area, you relied on your literature review you just described, you relied on the documents that are listed in attachment 2 of your report, and you relied upon letters submitted by the individual retirees.

Is there anything else that you have relied upon to form your opinions in this case?
A. I did not rely upon the letters from the retirees in the formation of my opinion.
Q. Okay. You cite them in your report. What -- how would you describe what you did with them, if you don't call that reliance?
A. Earlier on we talked about the report that was submitted in June --
Q. Um-hum.

A. -- that mirrors this report. The difference really between the two is -- are the citations from the retiree letters, which served to provide real world examples of the cited research and my opinion.
Q. Okay. You wouldn't say that your report rises and falls on those retiree letters, would you?
A. As I just said, they were to provide real world examples, but my opinion was based on my experience and the literature.
Q. Did you find the retiree letters credible?
A. Found that the retiree letters were consistent with the literature, in my opinion.
Q. Yeah. We'll look at some of that in a minute.
Okay. So in terms of what you relied on for your opinion, your experience, the review of the literature, the review of the documents listed in attachment 2 to your report, anything else that you relied upon for purposes of forming your opinions in this case?
A. I do not believe so.
Q. Okay. You did not do any field work, I assume?
A. What do you mean by, "field work"?
Q. You didn't go out and personally interview any of the retirees?
A. No.

Q. Did you find that credible?
A. Yes.
Q. Okay. Let's look at footnote 21, which cites to a letter from a, I think, Mr. Michael Darin. Davis, you had. It appears to me like it might be Darin, but it does say Davis.

Are you on page 12, footnote 21?

A. I am.
Q. And there the quotation is in the second paragraph. It says, A plan participant writes, Any new expense will completely ruin me. If it comes down to that point, I plan to stop taking my medications and let nature take its course, unquote.

Do you see that?

A. I do.
Q. Does it sound to you a little suspicious that two independent retirees used that same terminology?
A. It's a -- no. It's a common term of saying, I'll just let nature take its course.
Q. I'll stop taking my medications and let nature take its course. That didn't strike you as a suspicious turn of phrase?
A. No, it didn't. It's not that atypical for people to say those types of things.
Q. Would you entertain a hypothesis that use of that

terminology was as a result of a leading question or a comment that they might have heard?
A. I wouldn't know.
Q. Would it surprise you, or did you notice as you went through these letters, that there were a number of repetitive uses of particular phraseology in the 58 letters?
A. It did not strike me. I did not notice similar phraseology going through them, no.
Q. Would that be a concern to you, if it turned out to be the case, and if you had noticed it?
A. Not -- it would not be a concern if it's commonly-used phraseology.
Q. Do you recall any of the 58 letters providing complete financial information on the retiree's family?
A. Would you explain a little what -- you mean, like, their total income and assets and --
Q. Total pension income, total social security income, other income, assets.
A. I don't recall letters containing that type of information.
Q. Would that be relevant in evaluating the credibility of a retiree who is claiming that the increased cost would have a devastating impact and might lead them to discontinue all their prescriptions?

A. I wasn't asked to evaluate. I didn't have income data.
Q. Well, but my question -- but I'm asking you now, and that is: Would you find it -- and maybe you wouldn't. Would you not find total income and total asset information about a person claiming that a particular event was going to have a devastating financial impact relevant to evaluating the credibility of that person?
A. In order to -- the information that would be required would be extensive; not just assets, liabilities. It also would be subjective, because what is devastating to that individual might not be devastating to you or I.
Q. But it would at least be relevant data to determine if someone's claim of complete ruin as a result of an increased health care cost was credible or not?
A. I don't think that it's totally true, because again, it's subjective. We may say it's not complete ruin; but if they view it that way, and they're not willing to continue to take their meds because they feel it's financially ruinsome (sic), and they may have obligations that don't show up on their own personal financial statements, they're either taking care of their -- like, a disabled child or grandchild or something -- I don't know that we can pass that

judgment.
Q. We need more information than we've got from these letters to pass that judgment, don't we?
A. I don't know why you would want to pass that judgment.
Q. Well, to the degree it is relevant that the financial impact of these changes is devastating, don't we have to address that judgment?
A. Demonstrate it with the report prior to the letters that the retirees would be adversely impacted a number of different ways by the proposed changes.

MR. BURCHFIELD: I ask the reporter to mark as Daniels Exhibit 16 a copy of the decision of the United States Court of Appeals for the Sixth Circuit in Reese versus CNH America dated June 5 -- well, actually dated September 13, 2011.

MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 16
12:19 p.m.

BY MR. BURCHFIELD:
Q. Dr. Daniels, have you read this -- have you read this decision before?
A. Yes.
Q. And it's listed as one of the documents you rely upon in attachment 2 of your expert report, item number 4, correct?

impacted differently?
A. But they're going to be impacted regardless of their means. But the extent of that impact is a point-in-time observation. You could look today and say someone looks like they're all set, they're in good shape. That could change tomorrow for them.
Q. So would you or would you not agree that a prudent person making a determination of whether the plaintiffs individually are being -- are being seriously impacted by the proposed changes would look at their financial background?
Or if you don't think that would be pertinent information for a prudent person to look at, you may say so.
A. I don't -- there are impacts beyond just looking at cost of the change in the plan. If the network changes, providers change. So you could look at it from a financial point of view, yes, that's one piece of it, but there's other pieces to the change.
Q. Let's focus on the financial impact, because as I read the 56 letters -- 58 letters -- that's what they were focusing on, and that's what your report focuses on to a large degree, financial --
A. I disagree.
Q. Let's focus on financial impact. We'll talk about

health care outcomes after lunch.

Wouldn't you agree that, in order to evaluate the financial impact on the individuals of the class, it would be prudent to look at their financial situations?

A. If one felt that the financial aspect was critical, you could look at their financial status at a point in time, but knowing that is only a point-in-time assessment.

Q. We may all die tomorrow.

A. That's right.

Q. But you would consider -- you would consider it prudent to look at the financial information?

A. No. I said that you could look at it if what your focus is -- if your focus is on assessing a potential financial impact.

Q. That's the question. If we're interested in assessing the financial impact on the retirees, shouldn't we look at their financial information?

A. If you want to look at it individually, then yes.

Q. Okay. That's all I wanted to know. Thank you.

MR. BURCHFIELD: I tell you what, why don't we -- we're at probably a pretty good breaking point. Let me just ask -- let me just ask a couple questions, then we'll take a break for lunch, if that's okay.

BY MR. BURCHFIELD:
Q. On Daniels Exhibit 19 -- do you see that? This is the interrogatory responses by George Nowlin. And do you see, Dr. Daniels, his income information on page 3, down at the bottom of the page?
A. Yes.
Q. Okay. And just so you know, if you look at the first page of Exhibit 19, the caption of the case, just to confirm, Jack Reese is the lead plaintiff in this case. Do you see that?
A. I see that.
Q. And you see George Nowlin is also one of the named class representatives in the case?
A. I see that.
MR. BURCHFIELD: Okay. All right. Let's take -- let's take, you know -- do you want to take -- I'll take as much as you want, but I could probably do 30 minutes if we can get through the cafeteria in that period of time.
MR. CANZANO: Actually, 30 minutes is fine.
MR. BURCHFIELD: Okay. We'll do our best to get through the line in the cafeteria in that period of time and be back, you know, quarter after one or so.
MR. CANZANO: Okay.

wouldn't you, that there have been at least two noteworthy changes in federal health care programs, Medicare Part D and the Affordable Care Act?

A. Could you repeat the beginning of your sentence?

Q. Sure. You would agree with me that since 1998 there have been two noteworthy changes in federal health programs, Medicare Part D, and the Affordable Care Act?

A. I would agree that those are two of -- noteworthy changes.

Q. Any others you can think of?

A. Those are the most major ones.

Q. Any minor ones you can think of?

A. No, because they're mainly tweaks. We had Medicare part C for a while if you go back, things that didn't work out so well.

Q. Having now looked at this letter, does it have any effect one way or the other on the opinions you have ventured in this case?

A. No, it does not.

Q. I'm going to ask you to look at -- would you look at your report, Daniels Exhibit 6, note 2?

A. Page?

Q. And the text -- the text begins on paragraph 6, carries over to paragraph 7.

A. What page are you at?
Q. Page 6 of your report, Exhibit 6, the September report. And let me just read it into the record.

Access to health insurance plays a key role in retirement decisions. A study found that 54 percent of those surveyed indicated that access to retiree health insurance was, quote, extremely important, unquote, and another 28 percent reported that it was, quote, very important, unquote. And then footnote 2.

Do you see that?

A. Yes, I do.
Q. And in footnote 2 you cited -- there you go -- high employment cite -- you cited a document from the Employee Benefits Research Institute in January 2013; is that correct?
A. That's correct.

MR. BURCHFIELD: Let me ask the reporter to mark that document as Daniels Exhibit 22.

MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 22
1:41 p.m.

BY MR. BURCHFIELD:
Q. Dr. Daniels, after you've had a chance to look at this, would you please let me know if this is, in

fact, the survey that you cited in footnote 2 of your report?

A. Yes, this is the document.

Q. Now, this is a -- this is a survey, correct?

A. That is correct.

Q. They asked a number of people about what -- about, in figure 5, the impact of health insurance on their decision to retire.

Do you see that?

A. Correct, I see that.

Q. In looking at this document I did not see the actual questions that were asked. Did you happen to notice those?

A. No. This is a survey, though, that they routinely do on an annual basis, EBRI, and the methodology is telephone based. It's described on page 4.

Q. It says at the bottom of page 4, The HCS, the health confidence survey, was conducted between June 28 and July 20, 2012, through telephone interviews with 800 individuals ages 21 and older.

Do you see that?

A. Yes, I do.

Q. And given that we are -- given that the survey is asking questions about the relevance of various factors to a retirement decision, would it be

pertinent to you to know what portion of the survey respondents were in their 20s as opposed to in their 50s?

A. Well, it's a statistically-valid survey with results, so they don't -- they're not asking -- it's not a survey of just those nearing retirement age.

Q. So it wouldn't be relevant to you to know that?

MR. CANZANO: Could you repeat the question?

THE WITNESS: Yeah, repeat the question.

BY MR. BURCHFIELD:

Q. It wouldn't be relevant to you, I take it, to know what percentage of the survey respondents were in their 20s as opposed to their 50s?

A. It would be.

And the survey, though, the document -- and without rereading the entire study, though -- they are people that have worked a number of years, as indicated by they've worked longer than they had expected. So this isn't someone in their 20s, if you're -- referring back to the tables.

Q. I'm not sure -- I'm not sure we're -- maybe we're talking past each other.

My question for you is: If there were an even distribution of people in their 20s, 30s, 40s,

50s, and 60s, and the questions related to factors going into a retirement decision, would it bear on the credibility you've placed on the study to know that close to half of the survey respondents were 20 or more years away from retirement?

A. Well, if we refer back, this is focused on people that are closer to retirement, in my interpretation of this quickly, without going back.

Q. Where are you reading?

A. If we go back to figure 1.

Q. Right.

A. Let's see.

Q. Figure 1 is --

A. I'm sorry. I'm sorry.

Q. Figure 1 is sourced to something other than the survey on which you've relied.

A. I need to go back and refresh my memory, but the HCS is a survey that's focused on older workers and savings for retirement in general as well as this health care section. So it's not 20-year-olds.

Q. Well, you would agree that's not what it says. It says, The HCS was conducted between June 28 and July 20, 2012, through telephone interviews with 800 individuals, ages 21 and older.

MR. CANZANO: He's reading from right

there.

THE WITNESS: Yeah. But you're correct.

BY MR. BURCHFIELD:

Q. And it doesn't give a margin of error for the survey that I saw.

A. No, it doesn't report that out.

Q. And it doesn't give a breakdown of what the demographic distribution of the survey respondents is that I saw.

MR. CANZANO: I'm going to object to that as mischaracterizing the document.

BY MR. BURCHFIELD:

Q. Do you see a demographic distribution of the survey respondents?

A. They didn't do a survey that was aimed at identifying differences by demographics.

Q. So I take it the answer to my question is: No, there is no demographic distribution of the 800 survey respondents here?

A. I can't assume that.

MR. CANZANO: I'm going to object to that. Mischaracterizing the document.

BY MR. BURCHFIELD:

Q. Okay. Let me ask you that.

Can you point me anywhere in this document

that you cited in your report where it provides a demographic breakdown of the 800 people, ages 21 and older, that it surveyed from June 28 through July 20, 2012?

A. I do not see it in this document.

Q. So no margin of error stated, right?

A. Not in this report --

Q. Okay. No --

A. -- paper.

Q. No demographic breakdown, right?

A. Correct.

Q. No --

A. Based on this -- this is in a notes document and not necessarily the entire research brief.

Q. And no reiteration of the questions that were asked, right?

A. They are not contained in this document.

Q. Okay. You say, Not in this document.

Did you look at something other than this document?

A. No, I did not.

Q. So as you sit here today, you don't know whether that information is publicly available or not, right?

A. Which information?

Q. Margin of error, demographic distribution of the

sample, or -- or the questions?
A. The information is likely available. Whether it's publicly available depends, because some of EBRI's work, the more detailed work, is provided to their member organizations and not all of it to the public.
Q. But you haven't seen it?
A. No. I did not review it as part of this work.
Q. Now, you know that there are empirical behavioral studies that try to address the issue of health insurance benefits and their effect on retirement. You know that, don't you?
A. I'm not familiar with behavioral studies.
Q. You haven't -- are you not aware of studies that --
A. I don't know what you mean by "behavioral."
Q. That -- let me rephrase the question.
Are you aware of any studies that, using actual human behavior reacting to changes in health care structures, evaluate the greater or lesser likelihood of retirement?
A. Not that come to mind. It's the ones I've cited in this paper.
Q. You're not familiar with the Gustman and Steinmeier study with the National Bureau of Economics Research in March 1993?
A. Quite candidly, when I did my literature review,

documents, studies going back that far, are very dated.
Q. Okay. How about --
A. I try to find things more relev -- more current.
Q. How about David Blau and Donna Gilleskie, December of 2005, Health Insurance and Retirement of Married Couples, University of North Carolina Chapel Hill?
A. I don't believe that's one that I reviewed you were provided.
Q. How about Coe, Khan, and Rutledge, May 2013, Center for Retirement Research at Boston College?
A. I don't even know if these documents -- these are relevant to my work.
Q. But in any event, you didn't consider any of them?
A. No.
Q. The only source that you relied upon for your conclusion that health insurance -- that access to health insurance plays a key role in retirement decisions, the only external source you cite for that paragraph, is the EBRI survey that we talked about?
A. That and my experience.
Q. Okay. Let's talk about your experience.
What -- have you done any empirical analysis -- let me start more basically.
Have you done any published work on the

effect of health care -- of access to health care insurance on retirement outcomes?
A. No.
Q. Have you done any -- have you done any empirical research on that, which is to say, comparison of the actual retirement decisions of people under one health care regime versus another health care regime?
A. I have not.
Q. Have you done any methodical surveys of persons within the range of retirement decision-making on that issue?
A. No.
Q. Have you conducted methodical meetings with potential retirees who are considering retirement?
A. From a research perspective?
Q. Yes.
A. No.
Q. What is your experience in this area, Dr. Daniels?
A. It ranges from work at the UAW, attending retiree meetings, pre-retiree meetings, continued work after the UAW at the Greater Detroit Area Health Council, which also then involved trust funds and others, and as health care costs continue to rise, there's much written about individuals wanting to continue to work because of the health care benefits, as well as to date we see it.

Q. And others have studied those issues, but you haven't in a methodical way?
A. That's correct.
Q. Okay. By the way, Dr. Daniels, with regard to Daniels Exhibit 22, the EBRI survey, looking back at figure 5 on page 6, you would agree with me, wouldn't you, that, as that chart is constructed, it doesn't shed much light on whether the survey respondents were addressing a binary system, full health insurance, or no health insurance; or whether they were addressing the gradations of health insurance?
A. This uses the term health insurance as a single term.
Q. So that could be retire with health insurance or retire without health insurance, right?
A. That is correct.
Q. And here we know that the changes that are being made in the health program are not eliminating health insurance; they are simply increasing the cost-sharing, correct?
A. I disagree.
Q. How do you disagree?
A. You're eliminate -- the prescription drug benefit is eliminated under the proposed plan for the Medicare eligibles.
Q. But Medicare eligibles do have prescription drug

coverage available to them through Medicare Part D, don't they?
A. Only if they elect to purchase such coverage.
Q. But it's available, right?
A. Well, certainly it's available, but it's eliminated.
Q. And you would agree with me that this survey, the survey results reported in table 5 of Exhibit 22, don't distinguish as to whether it's -- whether the retirees would pay for the program themselves or whether they would have it provided to them?
A. I don't think I'd go to that conclusion. I disagree.
Q. What --
A. It says they worked longer because they wanted to continue to have health care insurance through their employer.
Q. Based on that chart, do you draw conclusions about whether the persons being surveyed there were taking into account the potential availability of Medicare Part D?
A. I can't draw a conclusion such as that. There's not sufficient detail.
MR. BURCHFIELD: Let me ask the reporter to mark as Daniels Exhibit 23 a document entitled A Preliminary Expert Report of Suzanne Paran --
THE WITNESS: Paranjpe.

MR. BURCHFIELD: -- Paranjpe, dated June 27, 2011.

MARKED BY THE REPORTER:

DEPOSITION EXHIBIT 23

2:00 p.m.

BY MR. BURCHFIELD:

Q. Dr. Daniels, do you recognize Exhibit 23 as an expert report that you submitted in the case of Thomas Temme and Shirley Temme, individually and as representative of a class, versus Bemis Company, on or about June 27, 2011?

A. Yes.

Q. And is the -- is that your signature on the last page, page 4 of the document?

A. Yes.

Q. And at that point this -- the Suzanne Par --

A. Paranjpe.

Q. -- Paranjpe, Ph.D., is the person we now know as Dr. Suzanne M. Daniels, Ph.D., correct?

A. That is correct.

Q. Okay. Great. Just to be clear.

Let me ask you to look, please, on page 3 of that document. Just above The Facts Considered there's a paragraph that says, It is my opinion that an appropriate, alternative approach is to adjust the

who were Medicare eligible?
A. That is my recollection.
Q. Okay.
A. Yes, for Daniels 25, yes for both.
Q. And are these -- both of these -- are both of these opinions, 24 and 25, from the same case, or are they different cases?
A. Just think for one second.
They're separate legal actions against TRW. They're different groups.
Q. Okay. And if you don't recall, just say so, but do you remember what the distinguishing characteristics of the two groups are in one case versus the other?
A. I don't -- there's some var -- I don't exactly remember, but there was some variation in benefits and contributions. But I don't recall with this one.
Q. Okay. Let's now turn back to Daniels Exhibit 7, which is your rebuttal report or your addendum, if we could.
Do you have that in front of you?
A. I do.
Q. And in that report you are responding to Mr. Macey's report to the degree it relies upon a Robert Wood Johnson report by Katherine Swartz entitled Cost-sharing: Effects on Spending and Outcomes; is that correct?

A. I -- this is in response to his section 2B3 of his report.
Q. Okay. And you discuss in here, don't you, Dr. Swartz' paper?
A. I do.
Q. Well, I see it, I just can't get it out of the box.
MR. BURCHFIELD: Let me ask the reporter to mark that paper as Daniels Exhibit 26.
MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 26
2:13 p.m.
BY MR. BURCHFIELD:
Q. Dr. Daniels, do you recognize Daniels Exhibit 26 as the -- as the Cost-sharing: Effects on Spending and Outcomes paper by Dr. Katherine Swartz that you discussed in your rebuttal report, Daniels Exhibit 7?
A. Yes.
Q. And did you -- I take it that the only source that you have relied upon -- or let me start again.
The only source you have cited in your December 16, 2013, report, Daniels Exhibit 7, is the Swartz paper.
A. That is correct.
Q. Okay. Now, am I correct that Dr. Swartz relied in some measure on the Rand Health Insurance Experiment,

which was designed between 1970 and 1974, and conducted between 1975 and 1978?

A. This work by Swartz is a survey of the literature, in essence, and not a study that would you cite something to rely on, but rather to really summarize the landscape of work that's been done in the field.

Q. Okay. I'll try to find it.

Let me ask you to look at the page of Daniels Exhibit 26 which has the last three digits at the bottom, right-hand corner 923 -- oh, I'm sorry, it's the page with the heading Methodology Overview.

Are you with me?

A. I am.

Q. And it says -- it is page 7. I see that now. It's -- in the first paragraph there it says, The rapid changes in medical care, along with changes in health insurance cost-sharing provisions, make studies done before 1990 less relevant for this review. Because it is so expensive to conduct a large, randomized experiment such as the Rand -- that's R-a-n-d -- Health Insurance Experiment, no experiments with variations in health insurance design have been conducted since the HIE, the health insurance experiment.

Do you agree with that statement?

A. That -- I agree that experiments have not been conducted, and the key word is experiments.
Q. Okay. And then she goes on to talk about some of the studies and says, in the second paragraph, Unfortunately, many of the empirical studies of the effects of patient cost-sharing are based on cross-sectional data, which are collected at only one point in time. The problem with using cross-sectional data to analyze the effects of cost-sharing is that individuals often have some choice about the type of health insurance they have, and the choice of cost-sharing requirements could be driven in part by how healthy a person is or how much care the person expects to use. In this case, it is hard to disentangle the effect of cost-sharing from the effect of, say, the individual's health.

Do you see that?

A. Yes.
Q. And do you agree with her statement there?
A. It's difficult. Does not mean impossible.
Q. Okay. Would you look at page 10, please, under the heading Findings? And in the first bolded finding there it says, Reductions in patient-initiated care in response to increases in cost-sharing are likely to come predominantly from the half of the population who

have low medical expenses, people who most likely are healthy.

Do you see that?

A. Yes.

Q. And do you agree with that?

A. Yes. In the context of the population that she's looking at for this report, yes.

Q. And what is your understanding of the population she's looking at here?

A. Her focus of this work is on the -- those under -- the non-Medicare eligibles that are covered under Health Care Reform under the ACA. That's her stated purpose in the introduction.

Q. Let me ask you to look at the bottom of page 11, and the bolded heading says, What of the effects of increased cost-sharing on health outcomes.

And it says, There has not been a study on the effects of increased cost-sharing on the health of a general population since the Rand HIE.

Do you agree with that?

A. Yes.

Q. And then she goes on to say -- at the end of that paragraph she says, As noted above, however, the HIE found that people with higher cost-sharing reduced their use of both appropriate and inappropriate health

care services about equally. One hypothesis from this finding is that any negative effects due to reducing appropriate health care were matched by reducing inappropriate care that sometimes causes adverse health effects leading to hospitalizations.

Do you see that?

A. Yes.

Q. And I take it you mention -- you mentioned earlier the Dartmouth Atlas study which talked about overprescription and overutilization. Do you remember that?

A. Variations in care.

Q. And you would agree with me, wouldn't you, that to the degree there is a reduction in usage as a result of cost-sharing, some of that reduction could be reduced overutilization, which can have adverse health effects on the patients?

A. It could have -- it could address overutilization of those adverse things.

Just to clarify, though, the Dartmouth Atlas isn't as focused on drug overuse as medical procedures.

But on the other hand, cost-sharing, as in this last sentence you read, clearly if someone doesn't seek the appropriate care, it can result in

greater costs and increased hospitalizations. And that's the point she is making. And which continues, the adverse effects of cost-sharing, onto the next page in her findings.

Q. But let's stay on this point for a second.

As I understand what she's saying in that last sentence on page 11, she is saying that there could be some reduction of necessary beneficial care with adverse health outcomes, but there may also be some reduction of unnecessary care which would have had an adverse health effect; and, she further suggests, those two effects might have a tendency to balance each other out.

Is that not the way you read it?

A. Balancing it out in terms of measuring in terms of saying inappropriate and appropriate doesn't balance it out for the individual involved.

Q. Let me just ask this question: What -- is there -- am I correct that other than Dr. Swartz' survey of the literature here, Exhibit 26, none of the reports that you have submitted in this case cite any authority on the issue of health effects of cost-sharing?

A. That is not correct.

Q. What other sources do you cite for adverse effects of cost-sharing?

A. Page 9.
Q. You're on Exhibit 6?
A. Yes. A and B.
Q. And I see what you're pointing to, Dr. Daniels, but as I read those paragraphs, and I think I scanned those studies, my recollection is that they talked about the use -- patient's use of medications because of costs in paragraph A, but they did not evaluate the health outcomes as a result of that use -- of that reduced use of medications. Do you read it differently?
A. There's a difference between short-term and long-term health outcomes.
Q. I understand.

But do you understand those -- the study cited there in footnote 12, the JAMA study, do you recall that that study addressed either short- or long-term health consequences --

A. I believe it did.
Q. -- of the...
A. Sorry.
Q. Okay. You believe it did?
A. My recollection is that it did.
Q. Okay. And do you recall, as you sit here, what the quantification of those adverse health outcomes was?
A. I don't recall the quantification.

Q. And same issue with regard to paragraph B. The New England Journal of Medicine study suggested that copayments resulted in foregoing necessary outpatient care, leading to increased use of hospital care, but it doesn't -- that doesn't seem to me to address a health outcome.

A. When you think about something that could have been treated on an outpatient basis, the individual ends up not seeking the care due to costs, they end up in the hospital, it's a higher level intensity of service, means that they're not as well-off health-wise.

Does it go to the end point, based on this extract here, of did they die? In some cases, maybe; some cases, maybe not.

But it is an issue -- I mean, it is true with -- that, when you move to a higher intensity of care, it's because of your health needs being greater. So there is an adverse effect on ones health.

Q. Do you know if the -- if the New England Journal of Medicine study and the JAMA study were reviewed in Dr. Swartz' article?

A. I'd have to go back and cross-match it, but she had similar findings that she reported in her study, as I noted in my report.

Q. Okay. If you look at Daniels Exhibit 26, on page 33

is the citation of the sources. Source number 127 seems to be, does it not, The Journal of the American Medical Association piece by Tseng, CW Tseng?

A. Yes.

Q. T-s-e-n-g?

A. Yes.

Q. Do you understand my question? My question is --

A. I said, I believe so.

Q. Thank you. I did not hear your answer.

And then the study referred to in subparagraph B, is that entry number 125 in Dr. Swartz' appendix?

A. I would need to confirm that with my files.

We did provide you all the actual -- we can pull that and double-check it.

Q. Um-hum. Okay. Let me ask you to look at the Swartz -- in the Swartz article, Daniels Exhibit Number 26, first at page -- on page 9 just above the last bold heading, and the sentence right above that heading says, The newly-released rules for health insurance plans created by the PPACA eliminate cost-sharing for four sets of preventive services, and Medicare also will no longer face cost-sharing for most preventive services as of January 2011.

Do you see that?

A. No.
Q. I'm on page -- actually I'm on page 18. I'm sorry. I was looking at the footnote number. I apologize.
A. Okay.
Q. It's the -- I'm having a hard time reading these numbers. Maybe it's 16. It's the page with footnote nine at the bottom, whatever that is.
MR. CANZANO: Yeah.
BY MR. BURCHFIELD:
Q. Okay. Are you with me?
A. Now, yes.
Q. It says -- at the last sentence before the bottom heading, says, The newly-released rules for health insurance plans created by the PPACA eliminate cost-sharing for four sets of preventive services, and Medicare also will no longer face cost-sharing for most preventive services as of January 2011.
Do you see that?
A. I do.
Q. Is that accurate, so far as you know?
A. Yes.
Q. And then over on page 21, under the heading Findings, and this refers to -- let me just read the entire paragraph. It says, Schneeweiss and Zhang specifically examined the effect of Medicare Part D

coverage gap on the use and out-of-pocket spending of beneficiaries who reached the coverage gap.

And, Dr. Daniels, you understand that to mean the doughnut hole?

A. Yes.

Q. Okay. Using different data sets, both studies found that people who reached the coverage gap reduced their use of drugs in the months after they were affected by the gap. Zhang, et al, estimated such beneficiaries reduced their drug use by 14 percent, 0.7 prescriptions per month, and Schneeweiss estimated that their use of drugs in four drug classes of the study declined at the rate of 4.8 percent to 6.3 percent per month after they reached the gap. Zhang, et al, also had data on people who had coverage for generic drugs in the coverage gap. Some of these people switched from brand name to generic drugs, but in general these people reduced the number of their prescriptions by only 0.14 prescriptions per month.

Do you see that?

A. I do.

Q. And do you know, Dr. Daniels, whether in the CNH plan the so-called doughnut hole is reduced as a result of the out-of-pocket annual maximums?

A. I'm not following you as far as the -- a doughnut hole

in the CNH plan.
Q. Under Medicare Part D which the CNH -- which the retirees in this case would be able to avail themselves under the proposed plan, do you know if there is doughnut hole protection, if you will, as a result of the limit on out-of-pocket spending per year?
A. Typically not.
Q. Do you know in this plan one way or the other?
A. It would not -- under this plan the drug benefit is no longer part of the medical plan benefit. Its individuals are being, under the proposed plan, asked to go to the private marketplace if they want drug coverage. There's no integration done of the out of pockets.
Q. Let me ask you to look at the -- at the heading -- the last heading there on page 21, the last finding. It says, Long-term health effects of reduced use of essential drugs, especially for people with chronic health conditions, are unknown.
A. I would -- it's stated there, yes.
Q. Pardon me?
A. Yes.
Q. Okay. Are you aware of any -- of any studies to the contrary?

A. Actually, Swartz on page 12 discusses other studies with other results relating to cost-sharing of prescription drugs.
Q. I understand.
A. And page 12 would show an adverse effect, the last sentence -- last two sentences on that page in particular.
And arguably the Goldman study as well.
Q. Okay. But having discussed all the literature, her finding is that: Long-term health effects of reduced use of essential drugs, especially for people with chronic health conditions, are unknown.
Do you agree that's her finding on page 21?
A. I would refer back and would suggest that it's her conclusions that are critical. And she has findings in two sections, so I don't know how one can determine that findings are findings. They're not findings.
MR. BURCHFIELD: Okay. Why don't we take about maybe five minutes. Let me review my notes. I think I'm pretty close to being done.
MR. CANZANO: Okay.
(Recess taken at 2:42 p.m.)
(Back on the record at 2:51 p.m.)
BY MR. BURCHFIELD:
Q. Dr. Daniels, can we turn to your -- to Daniels Exhibit

6, your September report? And I'm on page 7, paragraph 9.

A. Yes.

Q. In paragraph 9 you say that, In my experience, and based on published research, retirees who are generally on fixed incomes are not able to afford even small increases in their expenses without hardship.

And it continues, and then -- and then you get to the next paragraph, says, A recent published study asked retirees about their ability to pay for a $2,000 unanticipated expense should it occur in the next month. The study found that only 50 percent of workers and 52 percent of retirees surveyed stated that they would definitely have $2,000 to cover the expense.

And then it says, Another published study found that 40 percent of retiree households had expenses that exceed their income, and over 14 percent of retiree households had spending that exceeded 75 percent of their income.

You followed all that?

A. I did.

Q. The study cited there in footnote 6, that's a survey, right?

A. That is correct.

JACK REESE, FRANCES ELAINE PIDDE, JAMES CICHANOFSKY, ROGER MILLER, and GEORGE NOWLIN,

Plaintiffs,

vs. Case No. 2:04-cv-70592-PJD-PJK
Hon. Patrick J. Duggan, U.S.D.J.
Hon. Paul J. Komives, U.S. Mag. J.

CNH GLOBAL N.V. and CNH AMERICA LLC,

Defendants.

_____

VERIFICATION OF DEPONENT

I, having read the foregoing deposition consisting of my testimony at the aforementioned time and place, do hereby attest to the correctness and truthfulness of the transcript.

_____

SUZANNE MARIE DANIELS, Ph.D.

Dated:

ERRATA SHEET

PAGE	LINE	READS	PAGE	LINE	SHOULD READ

_____

SUZANNE MARIE DANIELS, Ph.D.

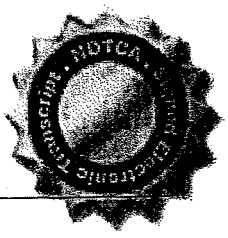
Dated:

CERTIFICATE

STATE OF MICHIGAN

COUNTY OF OAKLAND

I, Mary Jo Power, a Notary Public in and for the above county and state, do hereby certify that this deposition was taken before me at the time and place hereinbefore set forth; that the witness was by me first duly sworn to testify to the truth; that this is a true, full and correct transcript of my stenographic notes so taken; and that I am not related, nor of counsel to either party, nor interested in the event of this cause.



Mary Jo Power

Mary Jo Power, CSR-1404

Notary Public

Oakland County, Michigan

My commission expires: December 12, 2018